

# House File 2474 - Introduced

HOUSE FILE \_\_\_\_\_  
BY UPMEYER

Passed House, Date \_\_\_\_\_ Passed Senate, Date \_\_\_\_\_  
Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_ Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_  
Approved \_\_\_\_\_

## A BILL FOR

1 An Act relating to chronic care management.  
2 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:  
3 TLSB 6235YH 82  
4 pf/rj/5

PAG LIN

1 1 Section 1. NEW SECTION. 135.158 DEFINITIONS.  
1 2 For the purpose of this division, unless the context  
1 3 otherwise requires:  
1 4 1. "Chronic care" means health services provided by a  
1 5 health care provider for an established clinical condition  
1 6 that is expected to last a year or more and that requires  
1 7 ongoing clinical management to attempt to restore the  
1 8 individual to highest function, minimize the negative effects  
1 9 of the chronic condition, and prevent complications related to  
1 10 the chronic condition.  
1 11 2. "Chronic care information system" means approved  
1 12 information technology to enhance the development and  
1 13 communication of information to be used in providing chronic  
1 14 care, including clinical, social, and economic outcomes of  
1 15 chronic care.  
1 16 3. "Chronic care infrastructure" means the state's plan  
1 17 for chronic care infrastructure, prevention of chronic  
1 18 conditions, and a chronic care management program, and  
1 19 includes an integrated approach to patient self-management,  
1 20 community development, health care system and professional  
1 21 practice changes, and information technology initiatives.  
1 22 4. "Chronic care management" means a system of coordinated  
1 23 health care interventions and communications for individuals  
1 24 with chronic conditions, including significant patient  
1 25 self-care efforts, systemic supports for the physician and  
1 26 patient relationship, and a chronic care plan emphasizing  
1 27 prevention of complications utilizing evidence-based practice  
1 28 guidelines, patient empowerment strategies, and evaluation of  
1 29 clinical, humanistic, and economic outcomes on an ongoing  
1 30 basis with the goal of improving overall health.  
1 31 5. "Chronic care plan" means a plan of care between an  
1 32 individual and the individual's principal health care provider  
1 33 that emphasizes prevention of complications through patient  
1 34 empowerment including but not limited to providing incentives  
1 35 to engage patients in the patient's own care; and clinical,  
2 1 social, or other interventions designed to minimize the  
2 2 negative effects of the condition.  
2 3 6. "Chronic care resources" means health care providers,  
2 4 advocacy groups, health departments, schools of public health  
2 5 and medicine, health plans and others with expertise in public  
2 6 health, health care delivery, health care financing, and  
2 7 health care research.  
2 8 7. "Chronic condition" means an established clinical  
2 9 condition that is expected to last a year or more and that  
2 10 requires ongoing clinical management.  
2 11 8. "Department" means the department of public health.  
2 12 9. "Director" means the director of public health.  
2 13 10. "Eligible individual" means a resident of the state  
2 14 who has been diagnosed with a chronic condition or is at an  
2 15 elevated risk for a chronic condition and who is a recipient  
2 16 of medical assistance or hawk=i program benefits, is a member  
2 17 of the expansion population pursuant to chapter 249J, or is an  
2 18 inmate of a correctional institution in the state.  
2 19 11. "Health care provider" means an individual,  
2 20 partnership, corporation, facility, or institution licensed or  
2 21 certified or authorized by law to provide health care services

2 22 within the state.  
2 23 12. "Health risk assessment" means screening by a health  
2 24 care provider for the purpose of assessing an individual's  
2 25 health, including tests or physical examinations and a survey  
2 26 or other tool used to gather information about an individual's  
2 27 health, medical history, and health risk factors during a  
2 28 health screening.

2 29 13. "Prevention and chronic care partnership" means a  
2 30 regionally based consortium of health care providers and  
2 31 chronic care resources that promote the health of community  
2 32 residents and prevention of chronic conditions, develop and  
2 33 implement arrangements for delivering chronic care, develop  
2 34 significant patient self-care efforts, and provide systemic  
2 35 supports for the physician-patient relationship.

3 1 14. "State initiative for prevention and chronic care  
3 2 management" or "state initiative" means the state's plan for  
3 3 developing a chronic care infrastructure for prevention and  
3 4 chronic care management, including coordinating the efforts of  
3 5 health care providers and chronic care resources to promote  
3 6 the health of residents and the prevention and management of  
3 7 chronic conditions, developing and implementing arrangements  
3 8 for delivering prevention services and chronic care  
3 9 management, developing significant patient self-care efforts,  
3 10 providing systemic support for the health care  
3 11 provider-patient relationship and options for channeling  
3 12 chronic care resources and support to health care providers,  
3 13 providing for community outreach and education efforts, and  
3 14 coordinating information technology initiatives.

3 15 Sec. 2. NEW SECTION. 135.159 PREVENTION AND CHRONIC CARE  
3 16 MANAGEMENT INITIATIVE == ADVISORY COUNCIL.

3 17 1. The director, in collaboration with the prevention and  
3 18 chronic care management advisory council, shall develop a  
3 19 state initiative for prevention and chronic care management.

3 20 2. The director may accept grants and donations, and shall  
3 21 apply for any federal, state, or private grants available to  
3 22 fund the initiative. Any grants or donations received shall  
3 23 be placed in a separate fund in the state treasury and used  
3 24 exclusively for the initiative.

3 25 3. The director shall convene an advisory council to  
3 26 provide technical assistance to the director in developing a  
3 27 state initiative that integrates evidence-based prevention and  
3 28 chronic care management strategies into the public and private  
3 29 health care systems. The advisory council, at a minimum,  
3 30 shall include all of the following members:

3 31 a. The director of human services, or the director's  
3 32 designee.

3 33 b. The director of the department of elder affairs, or the  
3 34 director's designee.

3 35 c. The commissioner of insurance, or the commissioner's  
4 1 designee.

4 2 d. A representative of the Iowa medical society.

4 3 e. A representative of the Iowa hospital association.

4 4 f. A representative of health insurers.

4 5 g. A medical social worker or home care professional.

4 6 h. A patient advocate.

4 7 i. A primary care physician.

4 8 j. A pharmacist.

4 9 k. A specialist in public health and epidemiology.

4 10 l. An expert in health outcomes research.

4 11 m. A representative of an entity that is taking a leading  
4 12 role in health information technology.

4 13 4. The advisory council shall elicit input from a variety  
4 14 of health care providers, health care provider organizations,  
4 15 community and nonprofit groups, insurers, consumers,  
4 16 businesses, school districts, and state and local governments  
4 17 in developing the advisory council's recommendations.

4 18 5. The advisory council shall submit initial  
4 19 recommendations to the director for the prevention and chronic  
4 20 care management initiative no later than January 1, 2009. The  
4 21 recommendations shall address all of the following:

4 22 a. The recommended organizational structure, including the  
4 23 recommended size and geographic boundaries of the regions of  
4 24 the state to serve as territories, for the prevention and  
4 25 chronic care partnerships. The advisory council shall also  
4 26 prioritize one of these regions to be used as an initial pilot  
4 27 for a prevention and chronic care partnership.

4 28 b. A process for identifying leading health care providers  
4 29 and existing prevention and chronic care resources within the  
4 30 prevention and chronic care partnership regions identified and  
4 31 for consulting with these providers and resources.

4 32 c. A prioritization of the chronic conditions for which

4 33 prevention and chronic care management services shall be  
4 34 provided, taking into consideration the prevalence of specific  
4 35 chronic conditions and the factors that may lead to the  
5 1 development of chronic conditions, the fiscal impact to state  
5 2 health care programs of providing care for the chronic  
5 3 conditions of eligible individuals, the availability of  
5 4 workable, evidence-based approaches to chronic care, and  
5 5 public input into the selection process. The recommendation  
5 6 shall also include a timeline for inclusion of specific  
5 7 chronic conditions in the initiative.

5 8 d. A method to involve health care providers in  
5 9 identifying eligible patients, which includes but is not  
5 10 limited to the use of a uniform health risk assessment.

5 11 e. The methods for increasing communication between health  
5 12 care providers and patients, including patient education,  
5 13 self-management, and follow-up plans.

5 14 f. The educational, wellness, and clinical management  
5 15 protocols and tools to be used by health care providers,  
5 16 including management guideline materials for health care.

5 17 g. The use and development of process and outcome  
5 18 measures, aligned to the greatest extent possible with  
5 19 existing measures, to provide performance feedback for health  
5 20 care providers and information on the quality of care,  
5 21 including patient satisfaction and health status outcomes.

5 22 h. Payment methodologies to align reimbursements and  
5 23 create financial incentives and rewards for health care  
5 24 providers to utilize prevention services, establish management  
5 25 systems for chronic conditions, improve health outcomes, and  
5 26 improve the quality of care, including case management fees,  
5 27 payment for technical support and data entry associated with  
5 28 patient registries, and the cost of staff coordination within  
5 29 a medical practice.

5 30 i. Methods to involve public and private groups, health  
5 31 care providers, insurers, third-party administrators,  
5 32 associations, community and consumer groups, and other local  
5 33 entities to facilitate and sustain the initiative.

5 34 j. Alignment of any information technology needs with  
5 35 other health care information technology initiatives.

6 1 k. Methods to involve appropriate health resources and  
6 2 public health and outcomes researchers to develop and  
6 3 implement a sound basis for collecting data and evaluating the  
6 4 clinical, social, and economic impact of the initiative,  
6 5 including a determination of the impact on expenditures and  
6 6 prevalence and control of chronic conditions.

6 7 l. Elements of a marketing campaign that provides for  
6 8 public outreach and consumer education in promoting prevention  
6 9 and chronic care management strategies among health care  
6 10 providers, health insurers, and the public.

6 11 m. A method to periodically determine the percentage of  
6 12 health care providers who are participating, the success of  
6 13 the empowerment-of-patients approach, and any results of  
6 14 health outcomes of the patients participating.

6 15 6. The director of human services shall obtain any federal  
6 16 waivers or state plan amendments necessary to implement the  
6 17 prevention and chronic care management initiative within the  
6 18 medical assistance, hawk=i, and IowaCare populations.

6 19 7. Following submission of the initial recommendations by  
6 20 January 1, 2009, the director shall select one or more regions  
6 21 for deploying and evaluating a prevention and chronic care  
6 22 partnership pilot project. Following deployment of the  
6 23 initial pilot project, the director shall work with the  
6 24 department of human services, insurers, health care provider  
6 25 organizations, and consumers in implementing the initiative  
6 26 beyond the population of eligible individuals as an integral  
6 27 part of the health care delivery system in the state. The  
6 28 advisory council shall continue to review and make  
6 29 recommendations to the director regarding improvements in the  
6 30 initiative.

6 31 8. Each prevention and chronic care partnership shall do  
6 32 all of the following:

6 33 a. Select, based on the recommendations of the advisory  
6 34 council, the chronic conditions for which chronic care and  
6 35 prevention services will be provided within the region after  
7 1 considering the prevalence of the chronic condition in the  
7 2 region and factors that may lead to the development of chronic  
7 3 conditions, the fiscal impact to the state of providing care  
7 4 for the chronic condition for the eligible population, the  
7 5 availability of workable, evidence-based approaches to chronic  
7 6 care for the chronic condition, and any public input received.

7 7 b. Determine how to implement the prevention and chronic  
7 8 care services on a regional basis in a manner that

7 9 participating health care providers and chronic care resources  
7 10 support.  
7 11 c. Develop a mechanism for health care providers and  
7 12 chronic care resources to participate in the partnership.  
7 13 d. Identify and disseminate evidence-based information to  
7 14 participating health care providers and chronic care  
7 15 resources.  
7 16 e. Assist in outreach programs to address chronic  
7 17 conditions.  
7 18 f. Recommend mechanisms to provide incentives for  
7 19 participation by health care providers and chronic care  
7 20 resources.  
7 21 g. Recommend and evaluate health information options to  
7 22 enhance the accuracy and efficiency of communications  
7 23 necessary to the delivery of chronic care.  
7 24 h. Collect data as recommended by the advisory council and  
7 25 director to evaluate the clinical, social, and economic impact  
7 26 of the partnership.

#### 7 27 EXPLANATION

7 28 This bill relates to prevention and chronic care  
7 29 management. The bill directs the director of public health,  
7 30 in collaboration with the prevention and chronic care  
7 31 management advisory council created in the bill, to develop a  
7 32 state initiative for prevention and chronic care management.  
7 33 The bill provides that the director may accept grants and  
7 34 donations, and shall apply for any federal, state, or private  
7 35 grants available to fund the initiative. Grants or donations  
8 1 received are to be placed in a separate fund in the state  
8 2 treasury and used exclusively for the initiative.  
8 3 The bill directs the director of public health to convene  
8 4 an advisory council to provide technical assistance to the  
8 5 director in developing a state initiative that integrates  
8 6 evidence-based prevention and chronic care management  
8 7 strategies into the public and private health care systems.  
8 8 The bill specifies the membership of the advisory council and  
8 9 directs the advisory council to elicit input from health care  
8 10 providers, health care provider organizations, community and  
8 11 nonprofit groups, insurers, consumers, businesses, school  
8 12 districts, and state and local governments in making its  
8 13 recommendations. The bill provides that the advisory council  
8 14 shall submit initial recommendations to the director for the  
8 15 prevention and chronic care management initiative no later  
8 16 than January 1, 2009. The recommendations are to address:  
8 17 the organizational structure for the prevention and chronic  
8 18 care partnerships which are regionally based prevention and  
8 19 chronic care delivery systems, and an initial partnership to  
8 20 be used as a pilot; a process for identifying leading health  
8 21 care providers and existing prevention and chronic care  
8 22 resources within partnership regions identified and for  
8 23 consulting with these providers and resources; a  
8 24 prioritization of the chronic conditions for which prevention  
8 25 and chronic care management services shall be provided and a  
8 26 timeline for inclusion of specific chronic conditions in the  
8 27 initiative; a method to involve health care providers in  
8 28 identifying eligible patients, which includes the use of a  
8 29 uniform health risk assessment; the methods for increasing  
8 30 communication between health care providers and patients;  
8 31 protocols and tools to be used by health care providers; the  
8 32 use and development of process and outcome measures to provide  
8 33 performance feedback for health care providers and information  
8 34 on the quality of care; payment methodologies to align  
8 35 reimbursements and create financial incentives and rewards for  
9 1 health care providers to utilize prevention services,  
9 2 establish management systems for chronic conditions, improve  
9 3 health outcomes, and improve the quality of care; methods to  
9 4 involve public and private groups, health care providers,  
9 5 insurers, third-party administrators, associations, community  
9 6 and consumer groups, and other local entities to facilitate  
9 7 and sustain the initiative; alignment of any information  
9 8 technology needs with other health care information technology  
9 9 initiatives; methods to involve appropriate health resources  
9 10 and public health and outcomes researchers to develop and  
9 11 implement a sound basis for collecting data and evaluating the  
9 12 clinical, social, and economic impact of the initiative;  
9 13 elements of a marketing campaign that provides for public  
9 14 outreach and consumer education in promoting prevention and  
9 15 chronic care management strategies among health care  
9 16 providers, health insurers, and the public; and a method to  
9 17 periodically determine the percentage of health care providers  
9 18 who are participating, the success of the empowerment of  
9 19 patients approach, and any results of health outcomes of the

9 20 patients participating.  
9 21 The bill directs the director of human services to obtain  
9 22 any federal waivers or state plan amendments necessary to  
9 23 implement the prevention and chronic care management  
9 24 initiative within the medical assistance, hawk=i, and IowaCare  
9 25 populations.  
9 26 The bill directs the director of public health, following  
9 27 the submission of the initial recommendations by the advisory  
9 28 council, to select one or more regions for deploying and  
9 29 evaluating prevention and chronic care partnerships pilot  
9 30 projects. Following deployment of the initial pilot project,  
9 31 the director shall work with the department of human services,  
9 32 insurers, health care provider organizations, and consumers in  
9 33 implementing the initiative beyond the population of eligible  
9 34 individuals as an integral part of the health care delivery  
9 35 system in the state. The advisory council is directed to  
10 1 continue to review and make recommendations to the director  
10 2 regarding improvements in the initiative.  
10 3 The bill also specifies requirements for each prevention  
10 4 and chronic care partnership.  
10 5 LSB 6235YH 82  
10 6 pf/rj/5